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ABSTRACT

This is a design for the evaluation of emergency family care programs of the San Francisco, California Home Health Services administration. The design objectives are qiven as the promotion of the health and welfare of the family unit and the reduction of the number of out-of-home placements of children and subsequent crises. The objectives of the design are stated as: (1) the development of simply administered assessment procedures to assist workers in makinq reliable decisions reqardinq service needs of high-risk families; (2) the monitoring and comparison of case management decision-making, service delivery, and client outcomes for families receiving aid other than emergency family care services; and (3) the study of the feasibility of merging data from a private provider with that from a public entity in order to monitor the quality of services given by child welfare agencies. The three phases of the proposed evaluation study include a basic evaluation, decision analysis, and comprehensive evaluation. The design presents a task analysis of evaluation procedures with respect to the program objectives, and eligibility criteria for emergency family care programs. Sample rating forms, a budget narrative, case plan summary and authorization forms, worker skill categories, and environmental assessment forms are appended. (JCD)

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DESIGN FOR THE EVALUATION OF THE SAN FRANCISCO HOME HEALTH SERVICES EMERGENCY FAMILY CARE SERVICES PROGRAM

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May 1981

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The Evaluation Problem

The child welfare system is presently unable to predict which children will require foster care services (Fanshel & Shinn, 1978, p. 506). Nor is it able to identify children for whom preventive services are most likely to have their intended effect (Jones, Neuman & Shyne, 1976, p. 127). The inability to make either of these predictions results in needless waste of scarce and valuable resources.

Organizations which have published the results of their efforts to provide in-home services commonly report that the families served have been known to one or more child-serving agencies, often for extended periods of time before the initiation of "preventive" services (Goldstein, 1973; Jones, et al, 1976). However, the greatest success in preventing future foster placements appears to occur in those families least known to the official child welfare system (Jones, et al, 1976, p. 125).

Most studies reporting on the "success" of in-home services to avoid foster care placement rely almost entirely on the workers' assessment during intake. For example, Jones et al (1976) set the eligibility criteria for a preventive services project that children were to be at risk for placement either immediately or within six months. To their surprise, about 8 out of 10 children in the control group were in the home of their parents at follow-up, compared to about 9 out of 10 children in the

experimental group (p. 82). Overall, 40 percent of the control group never entered placement (p. 91).

These data called into question professional performance in two distinctly different areas. First, how reliable is the worker's judgment of imminent risk for placement? Second, how valid are findings of positive outcomes reported by other studies which did not use control groups? Both of these questions have important implications in terms of resource allocation.

When children are placed inappropriately on the basis of a worker's unreliable decision, resources are affected in two ways. On the one hand, vast sums of money are being spent to care for a child who does not belong in a particular setting. On the other hand, a child who needs those services cannot take advantage of them because another child fills the caseload inappropriately.

When the agency with the inappropriate placement is subsequently evaluated, it may be reported that children return home quickly. But is it that the child returned to an improved home situation, or is it that the child returned home quickly because he or she should have never been removed from home? These examples illustrate why it is important for workers to make reliable, consistent decisions and why it is important to have control groups.

Finally, we have not yet empirically determined whether preventive in-home services are indeed beneficial for children - in either the short run or long run. That is, it is not enough to demonstrate that families remain

united. There is an additional obligation to determine whether the health, social, emotional and developmental needs of the children are safeguarded when they remain in their home in comparison to the available alternatives.

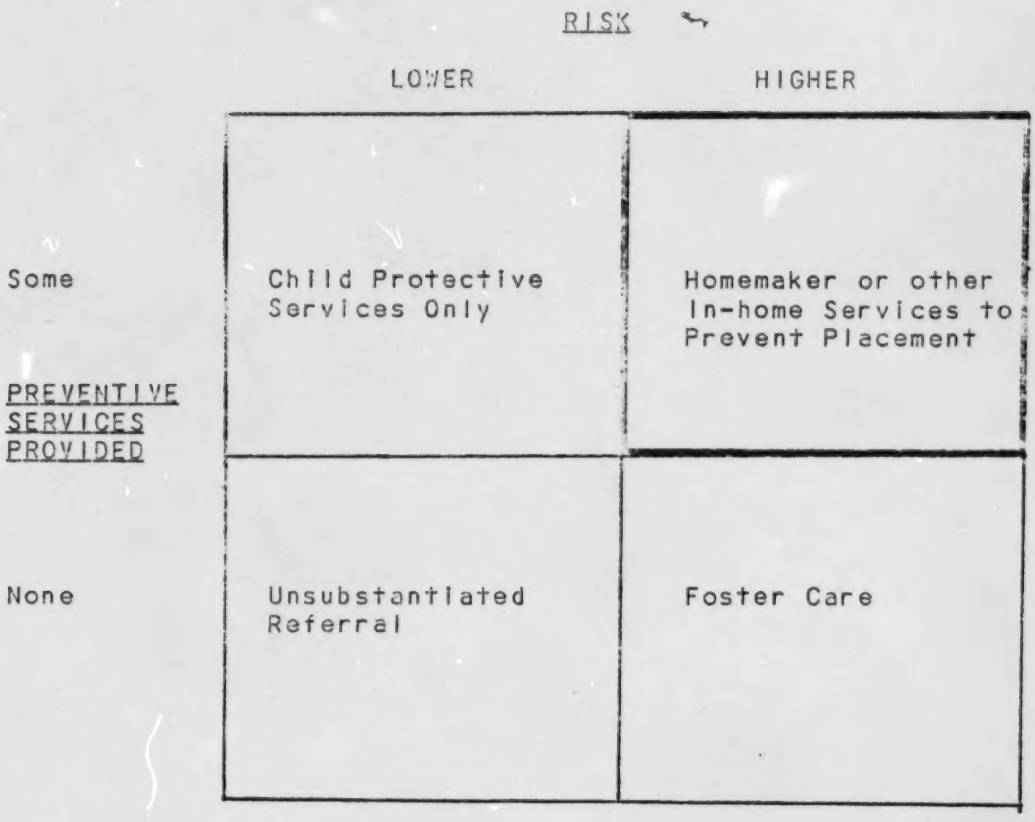
The current situation regarding research on the ability of in-home services to prevent future placement in foster care can best be summarized in Figure 1. The upper right-hand box of this figure indicates that previous efforts to evaluate preventive services tended to draw their samples from a single group: children known through their prior histories of service within agencies who are believed to be at considerable risk for foster placement. Further, the Jones, et al (1976) evaluation is the only known study where such children were randomly divided into served and unserved groups (with regard to in-home service) and followed prospectively. No studies are known which explicitly compared services and outcomes for other children at risk into the evaluation design for in-home services. These other potential comparison services are also indicated in Figure 1.

These weaknesses make it difficult to assess the true effectiveness of in-home services to prevent foster placement. The evaluation design for the Emergency Family Care Services (EFCS) program offered by San Francisco Home Health Services (SFHHS) begins to address these issues.

Evaluation Overview

The goal of this evaluation is to create a system of dynamic assessment and service guidelines capable of

FIGURE 1. Schematic summary of previous evaluations of programs to prevent children from entering foster care.



explaining the decisions workers make with regard to emergency family care service. These data will be analyzed to understand their influence on the subsequent outcomes for clients. The results will be fed back to workers and administrators in an easily understood format so that the system performance can improve. Thus the evaluation system will be iterative as well as dynamic.

The end product will be a computerized case management information system for in-home services. This system will be designed to merge with data from public social services to meet assessment, case planning and reporting requirements under P.L. 96-272. A major objective is to design the system so that it can be easily adapted by other child serving agencies who must also meet these reporting requirements.

Such an evaluation scheme is possible because an inexpensive micro-processor is available at SFHHS. This micro-processor is sufficiently self-contained to perform simple evaluative functions on the one hand, yet it is capable of being linked to larger computer systems for more complex analysis.

The initial data elements used for the evaluation will consist primarily of those from existing information systems and important variables from previous relevant research. Building on the work of others, we can go farther, faster than might otherwise be possible. The information will change as the practice wisdom of the workers involved in the current evaluation effort is

systematically included. As worker knowledge enters the data base, the evaluation process will come to be seen as more legitimate and helpful by those who use it.

The evaluation model builds from the logic of a decision-map such as that displayed in Figure 2a. At each decision-point, it will be possible to contrast information obtained from naturally occurring control groups. That is, families will divide into "Yes" and "No" groups after each decision is made. Information regarding these groups can then be explicitly compared. By this means, we will eventually be able to understand what information workers used to make their decisions, the relationship between those decisions and their subsequent case management activities, and the ultimate outcomes clients experience. The results can then be fed back to workers to help them improve their subsequent performance.

Given the practical limitations of this evaluation, the information will begin with the "Yes" answer to decision-point 2, "Does the family seek assistance?" Data will be analyzed to understand the relationship between the personal and situational characteristics of families seeking assistance and the subsequent decision by workers in different agencies with regard to decision-point 3, "Is this family appropriate for in-home services?" Comparing the groups of families judged appropriate and non-appropriate by workers in different agencies, SFHHS will be able to:

FIGURE 2a: BASIC MODEL OF THE EVALUATION FOR EMERGENCY FAMILY CARE SERVICES

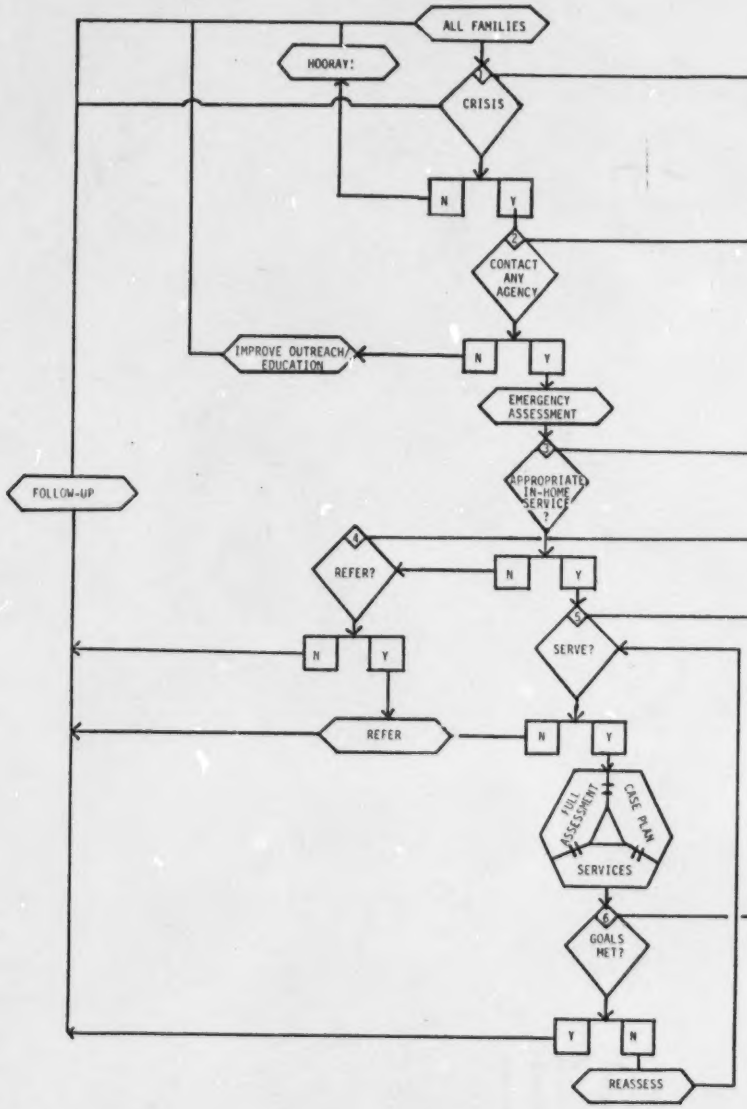


FIGURE 2b: SUMMARY OF THE EVALUATION MODEL

DECISION POINT	RESEARCH QUESTION	SYSTEM QUESTION	DATA BASE
1. IS THIS FAMILY IN CRISIS?	HOW ARE FAMILIES IN CRISIS SIMILAR TO AND DIFFERENT FROM FAMILIES NOT IN CRISIS?	WHAT SERVICES ARE NEEDED TO PREVENT THE ONSET OF FAMILY CRISIS?	CENSUS DATA: COMMUNITY SURVEYS; COORDINATION OF DATA FROM MANY AGENCIES
2. DOES THE FAMILY IN CRISIS REQUEST ASSISTANCE.	WHAT IS DIFFERENT BETWEEN FAMILIES IN CRISIS WHO DO AND NOT SEEK HELP; AND BETWEEN THOSE WHO GO TO INFORMAL VERSUS THE FORMAL HELPING SYSTEMS? TO DIFFERENT FORMAL SYSTEMS?	WHAT ARE THE IMPLICATIONS FOR PROGRAM DESIGN AND OUTREACH.	CENSUS DATA: COMMUNITY SURVEYS; COORDINATION OF DATA FROM MANY AGENCIES
3. IS THE FAMILY APPROPRIATE FOR IN-HOME SERVICE?	WHAT IS THE DIFFERENCE BETWEEN ELIGIBLE AND NON-ELIGIBLE CLIENTS?	WHAT ARE THE IMPLICATIONS FOR REFERRAL NETWORK, COMMUNITY OUTREACH, AGENCY LINKAGES?	ANALYSIS OF SFHHS DATA, FOLLOW-UP DATA, TRACKING, COORDINATION WITH OTHER AGENCIES
4. ARE NON-APPROPRIATE FAMILIES REFERRED ELSEWHERE FOR SERVICE?	WHAT HAPPENS TO CLIENTS WHO ARE REFERRED OUT COMPARED TO THOSE WHO DO NOT NEED SERVICE FROM ANY AGENCY?	ARE LINKAGES MADE? WHAT ARE SERVICE GAPS? CAN THEY BE FILLED BY SFHHS? IMPLICATIONS FOR PROGRAM DEVELOPMENT AND COMMUNITY COORDINATION.	ANALYSIS OF SFHHS CASE RECORDS, FOLLOW-UP INTERVIEWS, TRACKING, SOME DATA COORDINATION
5. ARE CLIENTS SERVED?	WHAT ARE THE RELATIONSHIPS BETWEEN CLIENT CHARACTERISTICS ARE THE CASE PLANS DEVELOPED FOR FAMILIES?	ARE SIMILAR CLIENTS TREATED SIMILARLY AND DIFFERENT CLIENTS TREATED DIFFERENTLY? ARE SERVICES INDIVIDUALIZED? ARE THEY EQUITABLE?	ANALYSIS OF SFHHS CASE RECORDS, FOLLOW-UP INTERVIEWS, TRACKING, DATA COORDINATION
6. ARE CLIENT GOALS MET?	WHAT IS THE RELATIONSHIP BETWEEN CASE PLANS, SERVICES DELIVERED, AND GOALS ATTAINED? HOW DO SIMILAR CLIENTS FARE IN OTHER AGENCIES? WHAT IS THE LONG-TERM OUTCOME?	WHAT CAN BE DONE TO IMPROVE THE PROGRAM? DID INTERVENTION MAKE A POSITIVE DIFFERENCE IN THE LIVES OF CLIENTS? HAVE THEY BEEN NORMALIZED? AT WHAT COSTS?	ANALYSIS OF SFHHS CASE RECORDS, FOLLOW-UP INTERVIEWS, TRACKING, DATA COORDINATION

- Determine whether appropriate referrals come to SFHHS for emergency family care services.
- Use that information to improve community education or agency linkages, strengthen the referral system, or change the internal structure of the EFCS program.

Figure 2b summarizes the relationships between the decision points, the major research questions, the system questions, and the data sources that will be drawn upon. Subsequent decision-points will be analyzed and the information used similarly.

An Example

Figure 3 presents a sample report that might be prepared. Basically, variables describing families referred from different agencies are correlated with subsequent decisions by SFHHS workers to accept a family for emergency family care services. Initially these variables will be drawn from previous relevant research; overtime, worker suggestions will be incorporated.

The next step is to compute an "acceptance equation" by means of step-wise regression. This equation will identify the information workers most commonly relied upon to make their service decision. If the proportion of variance explained by the statistical model is low, workers will be consulted to identify additional information they used to make their decision. Forms will be redesigned and data gathered again.

This process will repeat, or iterate, until the proportion of variance explained is acceptably high. At this point, the information system will conclude that the

FIGURE 3

Correlation between the independent variables of the study and the decision of appropriateness.

Case Characteristics	Agency Family First Approached		
	SFHHS	CES	Other
Familial			
X_1			
X_2			
etc.			
Children			
X_1			
X_2			
etc.			
Parental			
X_1			
X_2			
etc.			
Situational			
X_1			
X_2			
etc.			

*Only conditions significant at the .05 level are reported.

decision to accept a family referred for services has been "explained." The important predictor variables can then be compared to the eligibility criteria established by SFHHS to assess whether there is congruence with the criteria workers actually used.

Depending on the results of this comparison, a number of subsequent activities might be undertaken. For example, the analysis might discover that appropriate families are not being referred. SFHHS can then decide whether it wants to change its community outreach activities to alter the types of referrals being made, or whether it wants to accept the eligibility criteria the large community seems to have.

The analysis might indicate that appropriate families are being referred but not being accepted by SFHHS workers. Again, a number of decision alternatives are available. Staff training might be altered, supervision practices changed, staffing patterns changed to reflect the hours referrals are actually being made, or the eligibility criteria changed to reflect what the SFHHS workers seem to prefer in the way of clients.

This example illustrates what it means for an information system to be dynamic and iterative. The knowledge of others is used to begin the explanatory process. Appropriate forms are developed to reflect these information elements. The forms are completed by workers in the process of their daily activities. Data are analyzed and the results fed back to the appropriate

program level. Forms continue to be revised until acceptable information is obtained. Then decisions can be made to continue the system as it is, or to initiate planned, controlled change.

Evaluation Design and Procedures

Decision Model

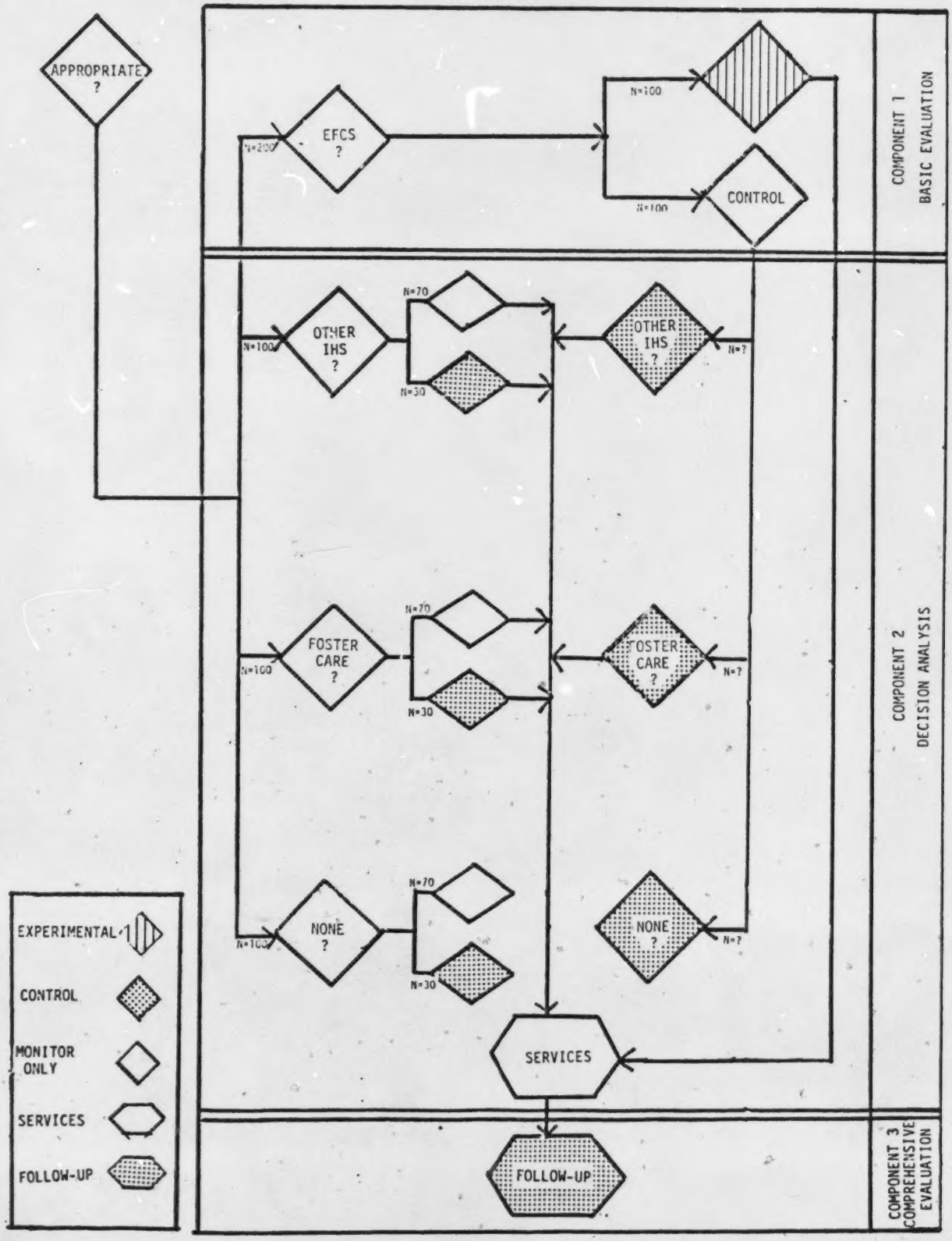
San Francisco Department of Social Service (DSS) workers presently make three basic decisions for families at risk:

- To provide some form of in-home services (IHS). These include such things as voluntary supervision, court-ordered supervision, counseling or therapy, or maintenance services such as food stamps, AFDC, etc.
- To provide some form of foster care services. These include such things as temporary out-of-home respite care, temporary or permanent foster family care, group home or institutional placement, or preparation for adoption.
- To provide no services. Some cases prove to be unfounded or inappropriate.
- The opening of the Emergency Family Care Services Program through SFHHS provides DSS workers with a fourth, previously unavailable option.

Given these options, Figure 4 presents a schematic drawing of the evaluation design. The figure basically expands the decision-map in Figure 2a by representing all possible options in addition to emergency family care. The design consists of three components, each addressing more complex evaluation issues with regard to the efficacy of emergency family care services. These are the Basic Evaluation, the Decision Analysis, and the Comprehensive Evaluation.

FIGURE 4

EMERGENCY FAMILY CARE SERVICE
EVALUATION DESIGN



This quasi-experimental design was selected to answer the central question of the effectiveness of intensive in-home services to families in preventing or shortening foster care placement without jeopardy to the well-being of the children. By using naturally occurring control groups which do not receive the demonstration services, we will be able to determine whether favorable outcomes can be ascribed to the services provided rather than to case selection, chance factors, or the passage of time (Campbell & Stanley, 1963).

In a true experimental design, experimental cases are exposed to a specific treatment, control cases are not exposed, and all other conditions are held constant. Such a design is virtually impossible in an evaluation which involves field operations in the human services. In contrast, this design compares cases randomly exposed, after assessment, to the emergency family care services in relation to control cases:

- Exposed by initial case decision to other treatments.
- Exposed by default to other treatments.

The availability of this information will allow us to study the relationships between the worker decisions, resource allocations, and subsequent outcomes.

Before, during and after the experimental period, referrals will be accepted from a variety of agencies. In-home data will be collected, analyzed and fed back on those families to the SFHHS workers. As a consequence of the analysis, the system will be up-graded and improved,

building on the knowledge learned in the earlier report period. The experimental period will begin approximately six months after SFHHS begins providing emergency family care services; it will conclude one year after the last family enters. For the families in the evaluation, additional data will be obtained.

Subjects

Each year approximately 1900 families come to the attention of the Comprehensive Emergency Services (CES) Unit of DSS. This unit makes an initial decision which is later implemented or changed by workers in other DSS units. Additionally, families already served in these other units may also be referred for emergency family care services without going through CES. The evaluation design basically involves following the progress of 500 of these families receiving some type of intensive assistance after the experimental period begins. These families will be divided into four basic groups:

- 100 families receiving the experimental services.
- A control group of 100 families initially appropriate for the experimental services but not accepted due to worker unavailability. As a result DSS workers will have to choose another option by default.
- A control group of 3 subsets of 30 families each (total = 90 families) initially deemed appropriate for other services.
- A monitoring-only group of 210 families appropriate for other services.

Each sub-group in Figure 4 will be filled during a period ranging up to six months after the evaluation period begins. For example, the groups of families assigned to EFCS are expected to fill rather quickly. The time it takes to fill each group will depend on the relative randomness of the following events:

- The order in which families come to the attention of the DSS.
- The speed with which workers make their decision.
- The order in which families appropriate for emergency family care services are referred to SFHHS.
- The availability of SFHHS staff to respond to the referral.

Eligibility Criteria

A worker considering a family for emergency family care services must believe that these services would reduce the risk of or need for out-of-home placement within two months of assignment to SFHHS. This restriction, of course, eliminates many cases that might benefit from intensive services requiring more than two months to accomplish the desired results. However, these latter cases do not seem to fall within the purview of the concept of "emergency" services, but rather in the realm of "rehabilitative" or "chronic" needs for service. After this basic criterion, the selection of cases appropriate for emergency family care services is left to professional judgment, within the following guidelines:

Family

- Lives within the city and county of San Francisco.
- Under severe stress or in a state of crisis in which it appears that emergency family care services is the only available alternative to out-of-home child placement.
- Capable of responding positively to intensive assistance within a two-month period.

Parent(s)

- Willing to accept the services of the family care worker; and
- Temporarily absent from the home due to illness or incarceration; and/or
- Manifesting mild to moderate child abuse or neglect toward one or more children; and/or
- Needing temporary assistance with child-care and/or household responsibilities because of illness of one or more family members, or because of parental depression of a short-term nature; and/or
- Needing in-home training with regard to proper health care, nutrition, sanitation, shopping, etc., in order to care properly for family.

Children

- At least one child under the age of 14, and either
- Believed to require placement within two months, or
- Awaiting placement away from home, or
- Having already been placed temporarily within the last 72 hours.

Data Sources and Evaluation Questions They Address

The data collection plan involves three major sources of case information. Each of these obtain unique information needed to answer important evaluation questions.

Basic Information System

Workers assigned to the 500 cases in the evaluation study (whether in SFHHS or in DSS) will maintain basic case management forms now used by DSS. These forms are presently required of all workers, so no additional activities are involved in collecting this data. Arrangments are being made with DSS to provide computer tapes for selected variables on the cases included in the evaluation. This source of case information will enable us to address the following questions:

- Are there basic demographic characteristics or presenting differences between families in the comparison sub groups?
- What is the relationship between these differences and the case management decisions?
- Do DSS workers treat cases in the control groups differently from cases in the monitor only groups? Has identifying the family led to differential treatment that might otherwise not have occurred had the family not been singled out? Did this lead to different outcomes?
- How many service contacts are made and what is the relationship between case activities and salient case factors?
- How many days are children in out-of-home placement in the different groups?
- What is the rate of case re-openings for the comparison groups?

- o What are the outcomes for the cases in each sub group one year later?
- o How do the alternatives compare in cost?

Decision Data

Using an iterative process, a series of experimental forms will developed by SFHHS during the first six months of the evaluation. The purpose of these forms will be to "explain" the various decisions made with regard to providing emergency family care services as compared to the other possible decisions. These forms will draw upon the work of Jones et al (1976), Fanshel (1976, 1978, 1979), Stein, Gambill and Wiltse (1978); Emlen, Lahti, Downs, McKay, and Downs (1978); Polansky, Chalmers, Buttenwieser, and Williams (1978), and others. Arrangements have already been made with most of these researchers to share the forms they developed for use by the emergency family care services evaluation. These data elements will be supplemented by the SFHHS Emergency Family Care Services staff.

When the evaluation period begins, these forms will be completed by workers in SFHHS and DSS serving the 100 experimental families in Component One and the 190 control cases in Component Two. This data collection activity will require a one-time effort per case on the part of DSS workers serving 190 cases. Since these families will be entering over a six month period, and since there are approximately 60 workers in the affected units, this will not be an onerous burden. This source of case information will enable us to address the following questions:

- What information do DSS workers use to distinguish families appropriate for emergency family care services from families appropriate for other options? How do these criteria compare to those used by SFHHS? Is SFHHS receiving appropriate referrals?

- Is there a predictable relationship between the risk characteristics of families experiencing different case management decisions and the subsequent case management activities and outcomes? Can the patterns of services and outcomes be distinguished one from another, especially in relation to those receiving emergency family care services?

- Are workers using similar information to make different decisions? That is, what affects the reliability and consistency of workers decisions?

- What is the relationship between these criteria and the data available from the basic information system?

- Can we develop a predictive model which indicates why workers decide a family is appropriate for emergency family care services over all other options?

- What is the relationship between decision-making criteria and subsequent case activities and outcomes?

Comprehensive Evaluation Forms

The final series of forms will be completed by parents and children, and by workers assigned to a special evaluation team. Again, data elements will be primarily drawn from the research of others, for example Moos, 1975; Jenkins and Norman, 1972; Fanshel and Shinn, 1978; Swire and Kavaler, 1978. The forms will be completed shortly after a decision is implemented, at six months, and one

year. The 100 EFCS families in Component One and the 190 control families in Component Two will be asked to participate in this portion of the evaluation.

The evaluation team will go to the homes of the families to obtain the data. These forms will not require any DSS or SFHHS direct service staff involvement. Because of the anticipated difficulty in getting families to participate in this phase of the evaluation, arrangements are being made to provide special incentives. These may take the form of donated tickets to special events such as the circus, meals at chain food restaurants, etc. This information will enable us to address the following questions:

- Are the health, social, emotional, and developmental needs of children receiving in-home services safeguarded in comparison to children receiving other services?
- What other community resources have families used?
- Does the family still have a need for family care services?
- How effective were the comparison services in aiding families in crisis?

Component One: Basic Evaluation

Description

The progress of 100 families (the experimental group) served by the Emergency Family Care Services program will be followed for one year after their entry. The data sources will consist of the Basic Information System and the Decision Analysis materials.

Objectives

To develop a dynamic, iterative, decision-focused case management information system for emergency family services. Using micro-processors capable of linking to larger computers, the system will form the core of the reporting and evaluative process.

Tasks

1.1 Identify the data elements needed to explain worker decisions.

1.2 Design forms and reporting formats.

1.3 Train workers to complete the forms at a 95 percent accuracy level.

1.4 Implement procedures to enter, process and report the data.

1.5 Disseminate the results.

Procedure

A series of forms will be developed to record services and outcomes. Selected data elements from the DSS case management system will be incorporated. The decision-focused assessment instruments will be derived from previous research and will incorporate the knowledge of the emergency family care service workers. The assessment guidelines and service records will be refined until they seem to capture most of the important information.

SFHHS workers will record case management information on the instruments in the course of their day-to-day activities. Data will be entered and stored as quickly as possible using the SFHHS Crememco micro-computer. When a sufficiently large data base has accumulated to justify

analysis, the case data will be processed. The results of this analysis will be fed back to workers and administrators at SFHHS, and to the funding and cooperating agencies.

Products

- o A brief written narrative report will be prepared at six month intervals.
- o A decision focused case management information system (CMIS) for emergency family care services programs will be developed.
- o At least one presentation will be made at an appropriate professional conference.
- o A final narrative report will be prepared.

Human Subjects Protection

Development of internal record keeping systems, data collection, and analysis done by an institution for operational monitoring of its own operations is not regarded as research under guidelines for the protection of human subjects (Belmont Report, 1978, p. 12-8).

Funding

Component One has been funded by the Ford Foundation. The budget for this component is $79,000. A report on work accomplished during the first six months will be available on June 15, 1981.

Component Two: Decision Analysis

Description

This portion of the evaluation will comparatively examine the criteria workers use when they make decisions

to direct families to specific service alternatives. The decision-focused instruments developed by SFHHS for the emergency family care service program will be completed for the 100 control cases served by DSS. These data will be compared to that provided by the SFHHS workers for the 100 emergency family care experimental cases. Finally, data from the Basic Information System will be compared for all 500 cases. The period covered by the Basic Information System will be one year, going forward from approximately Month 7 of the evaluation.

Objectives

- Develop a simply administered assessment procedure to help workers make reliable decisions regarding the service needs of high-risk families, particularly with regard to emergency family care services.
- Monitor and compare case management decision-making, service delivery, and client outcomes for families receiving other than emergency family care services.
- Study the feasibility of merging data from a private provider with that from a public entity in order to monitor the quality of services given by child welfare agencies to conform with the mandate of P.L. 96-272.

Tasks

2.1 Obtain a written agreement specifying the conditions and terms for transferring data from DSS to SFHHS.

2.2 Develop, implement, and monitor procedures to prospectively tag cases going through DSS.

2.3 Develop DSS worker support for the evaluation.

2.4 Test the assessment instruments developed by SFHHS on the control cases.

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2.5 Develop and implement the systems documentation, and procedures to transfer, enter, process, and report the data.

2.6 Disseminate the results.

Procedure

When the experimental period begins, the 500 cases involved in the evaluation will be tagged prospectively. DSS workers will not know initially which cases are in the monitor-only group. The 100 experimental cases, the 100 control cases initially appropriate for EFCS, and the 90 control cases (30 each receiving other in-home, foster care, or no services) will be selected by SFHHS. The experimental assessment and decision-making forms will be completed by workers in both agencies assigned to these cases. Every effort will be made to limit the number of cases completed by an individual DSS worker and to stagger each worker's cases over the experimental period. These instruments will be forwarded to SFHHS as they are completed for data processing and analysis.

Inital data regarding the personal characteristics of the 500 families will be forwarded to SFHHS on computer tape shortly after the data have been processed through the DSS system. The initial or presenting information will be integrated with the workers decision-making information. One year after the decision was implemented for either emergency family care, other in-home, foster care, or no services, the accumulated DSS case management data for all 500 families will be forwarded to SFHHS on computer tapes. It could take as long as twenty months

for all the follow-up data to be available (up to six months to fill each group, one year to track, and perhaps two months for DSS to process and transfer). These data will then be integrated into the other data components for analysis and reporting.

Products

- o A brief narrative report will be prepared during month 15.
- o The major findings of this analysis will be incorporated into the case management information system.
- o At least one presentation will be made at an appropriate professional conference.
- o A final report will be prepared.

Human Subjects Protection

A human subjects protocol will have to be prepared for this component of the evaluation for the following reasons. First, novel data collection activities will be initiated for the purpose of evaluating emergency family care services as a program alternative for DSS workers; second, administrative data gathered for one purpose will be shared with another agency for a different purpose (Belmont Report, 1978, p. 12-7).

The statistical analysis of DSS administrative records jeopardizes no client rights as long as no individually identifiable data are transferred out of the file of original custody into another file. For the uses that meet this requirement, the informed consent of the clients is not required (Belmont Report, 1978, p. 12-6). The data forwarded to SFHHS (on either the experimental

forms or the DSS case management system) will protect the identity of the specific family and are therefore exempt from the requirement of informed consent.

Funding

The Department of Social Services will commit time for workers to complete the forms developed by SFHHS and to carry out necessary data merging tasks. Thus, DSS plans a substantial commitment to this evaluation effort if funding can be secured. A letter to this effect is included with this proposal. The detailed budget of $110,768 for this component is described on page 36.

Component Three: The Comprehensive Evaluation

Description

The progress of the 100 experimental and 190 control cases will be followed for a period of one year after their entry into the service system. The data sources will consist solely of the Comprehensive Evaluation forms.

Tasks

3.1 Identify the basic data elements most likely to reflect qualitative and quantitative differences in outcome.

3.2 Design the basic forms needed to obtain the evaluation information.

3.3 Hire and train the intensive evaluation staff.

3.4 Standardize the interview procedures.

3.5 Develop inter-agency linkages which will facilitate interviewing the control group families.

3.6 Obtain sufficient incentives to motivate families to participate.

3.7 Interview 290 families immediately after the case management decision is implemented, again at six months, and one year later.

3.8 Implement procedures to enter, process, and report the data.

3.9 Develop the case management information system software package.

3.10 Disseminate the results.

Procedures

A team of supervised and trained home health evaluation workers will personally contact and interview the 100 experimental and the 190 control case families immediately after their case decision is implemented, at six months, and at one year. The in-home interview will include a brief health examination for the parents and children, a series of simple instruments to be completed by the parent(s) regarding their children's health and socio-behavioral functioning, an interview schedule covering increasingly long-term consequences of the decisions made earlier, and a series of instruments to be completed by the evaluation workers after the interview addressing qualitative aspects of the family environment.

This is expected to be the most sensitive component of the evaluation. Because of client mobility, it may be difficult to maintain contact with families over a period of one year. Clients may be openly hostile to the evaluation team interview. Workers may also be reluctant to have their clients contacted directly.

A number of tactics are proposed to improve our chances in carrying out this portion of the evaluation. The pre-experimental period will concentrate heavily on developing and testing initial contact and interview techniques which minimize problems with regard to client cooperation. Additionally, substantial effort will be made through in-service training and other activities within DSS to gain the cooperation of that agency's workers.

Products

- Brief narrative reports will be prepared during months 13, 19 and 25.
- A software package will be developed for analyzing the CMIS on a micro processor.
- At least two presentations will be given before appropriate professional conferences.
- A final written report will be prepared, integrating into it the results of the analysis from the other two components of the evaluation.

Human Subjects Protection

This portion of the evaluation will require a full human subjects protocol, including a review for informed consent. A five-member Review Board will be constituted, composed of two representatives each from DSS and SFHHS, and one independent member.

Comprehensive evaluation participants will be given a simply worded, printed statement informing them that the evaluation is being conducted in conformity with Federal legislation, describing the extent of their rights under this legislation, and providing the address and telephone

number of the Review Board to whom complaints should be directed. After the evaluation has been explained orally, participants will be asked to indicate their consent by signing the statement, which will be printed in their dominant language.

Funding

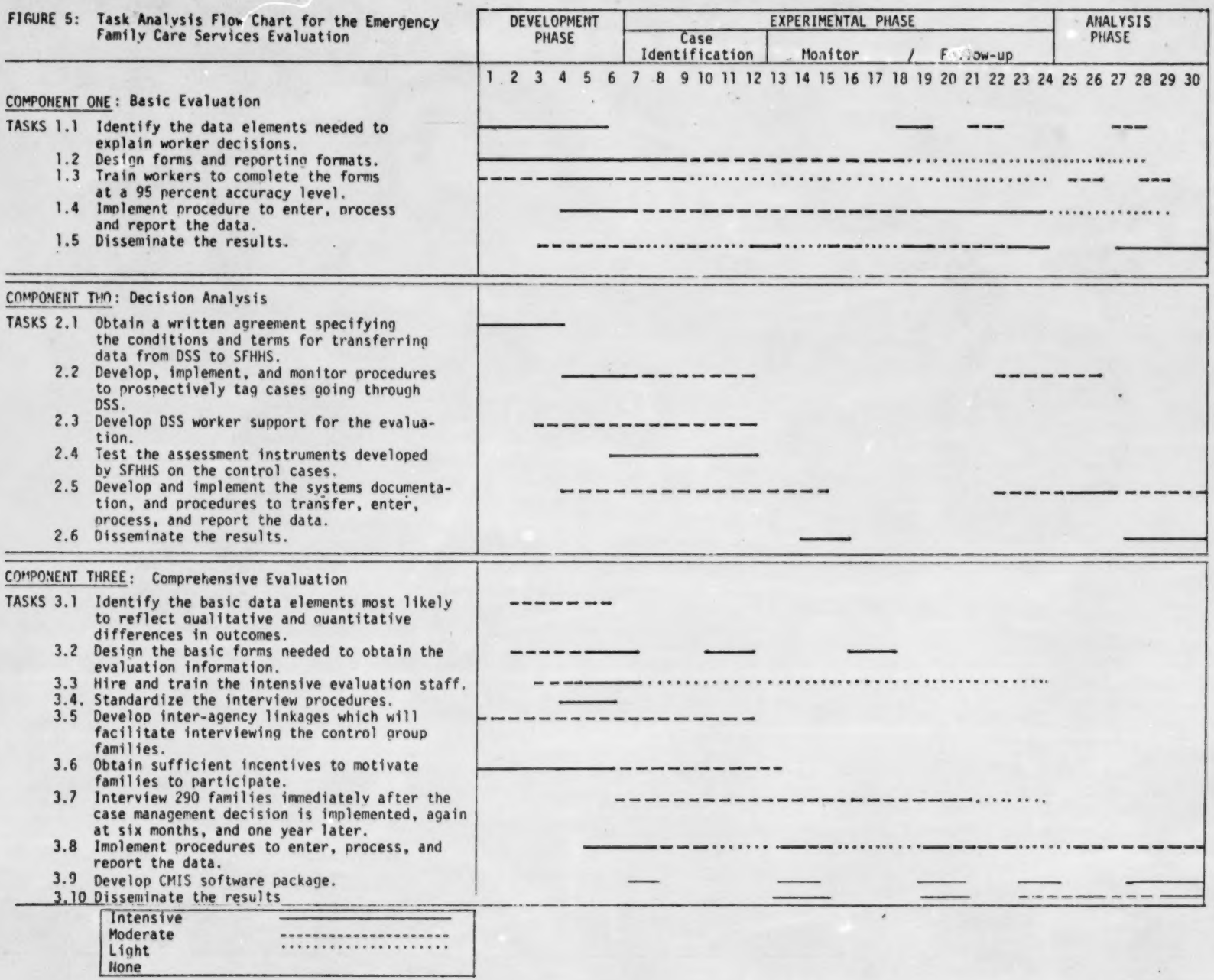
Due to the considerable research implications for this last component of the evaluation, SFHHS is applying to national foundations for a grant for the total amount of $235,271. The detailed budget is presented on page 37. This Component is also supported by DSS.

Task Analysis

Figure 5 indicates the best estimate of when tasks will begin and end, by evaluation component and evaluation phase. Looking across the top this figure indicates that the evaluation is composed of three major phases. The Development Phase occurs during the first six months. The Experimental Phase is divided into two segments: during Months 7 to 12, cases will be identified and served according to the evaluation design; during Months 13 through 24, monitoring and follow-up will be completed, again according to the individual evaluation components. Finally, the Analysis Phase will occur during months 25 to 30.

Because of the iterative design, the task analysis flow chart indicates periods of heavy, moderate, light, or no activity. During these periods of varying intensity,

FIGURE 5: Task Analysis Flow Chart for the Emergency Family Care Services Evaluation


DEVELOPMENT PHASE
EXPERIMENTAL PHASE
Case Identification
Monitor / Follow-up
ANALYSIS PHASE
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30
COMPONENT ONE: Basic Evaluation
TASKS 1.1 Identify the data elements needed to explain worker decisions.
1.2 Design forms and reporting formats.
1.3 Train workers to complete the forms at a 95 percent accuracy level.
1.4 Implement procedure to enter, process and report the data.
1.5 Disseminate the results.
COMPONENT TWO: Decision Analysis
TASKS 2.1 Obtain a written agreement specifying the conditions and terms for transferring data from DSS to SFHHS.
2.2 Develop, implement, and monitor procedures to prospectively tag cases going through DSS.
2.3 Develop DSS worker support for the evaluation.
2.4 Test the assessment instruments developed by SFHHS on the control cases.
2.5 Develop and implement the systems documentation, and procedures to transfer, enter, process, and report the data.
2.6 Disseminate the results.
COMPONENT THREE: Comprehensive Evaluation
TASKS 3.1 Identify the basic data elements most likely to reflect qualitative and quantitative differences in outcomes.
3.2 Design the basic forms needed to obtain the evaluation information.
3.3 Hire and train the intensive evaluation staff.
3.4. Standardize the interview procedures.
3.5 Develop inter-agency linkages which will facilitate interviewing the control group families.
3.6 Obtain sufficient incentives to motivate families to participate.
3.7 Interview 290 families immediately after the case management decision is implemented, again at six months, and one year later.
3.8 Implement procedures to enter, process, and report the data.
3.9 Develop CMIS software package.
3.10 Disseminate the results
Intensive
Moderate
Light
None

the appropriate tasks will be completed as indicated on the left side of the flow chart. For example, identification of the data elements (Task 1.1) will be a major activity during the first six months. It will cease during the first 12 months of the experimental period, resume for the last year of the evaluation, and finally taper in the amount of effort expended.

The major tasks were broken into sub-tasks which are not displayed on Figure 5. These included, for example, the numerous activities and expenses necessary to disseminate the results of the evaluation, the last task of each evaluation component. From this detailed task analysis, it was possible to determine how many days of work for what staff positions were needed to accomplish the major objectives. Having established the number of work days by position and by month of entry into the evaluation, budget expenses were calculated.

Budget Narrative

Staffing

The staffing pattern adopted for this evaluation mixes salaried staff and consultants. This staffing model was believed to be the most appropriate, given the short-term nature of the evaluation and the fact that most staff will terminate when the evaluation terminates. Their situation can be contrasted with that of the regular employees of the Emergency Family Care Services program, whose jobs will be on-going. Salaries for employees were calculated in the following manner:

- The cost of employing an individual full-time for 30 months (the duration of the evaluation) was calculated, including fringe benefits.
- This sum was divided by the number of work days in a year (260) to obtain a cost per day.
- The resulting figure was multiplied by the number of days the employee would be actually assigned to each component of the evaluation.

The cost of employing individuals was based on a 40-hour work week and provided the following items of time-paid-for-but-not-worked, according to the schedule of employee benefits for San Francisco Home Health Services.

- Vacation - 10 days per year
- Holidays - 9 days per year
- Sick Leave - 12 days per year

Other items related to staff expenses which are employer paid include:

- FICA - .0665 up to $29,700
- Unemployment Tax - .032 up to $6,000
- Workman's Compensation - .00635 with no ceiling
- Group medical insurance at $36.92 per month for 1981
- Life insurance - .005 of total salary

Finally, inflation and merit raises were included as follows:

- 0% for Year 1
- 10% for each of these for the subsequent years

Table I summarizes the results of this analysis, by employee position and by year of the evaluation. Knowing

TABLE 1: Staff Salary Schedule by Year

Position	Base Salary	Total Days	Cost Per Day 1981	1982	1983
Program Director Lou Fox, MSW, MPH	22,000	157	93.74	111.96	130.94
Comprehensive Evaluation Supervisor (to be filled)	24,120	247	102.50	122.40	143.21
Evaluation Worker BSW level position, (to be filled)	15,900	411	68.39	76.08	-0-
Secretary Linda Garcia	12,420	245	54.00	64.30	75.27
Data Entry Clerk (to be filled)	11,460	150	50.00	59.50	-0-
Consultants					
Senior Evaluator Principal Investigator Linda L. Remy, DSW		331	200.00	240.00	240.00
Programmer/Data Analyst Stuart P. Hanson, DSW (Cand.)		421	135.00	150.00	150.00
Relief Evaluator (to be filled)		60	68.39	76.08	-0-

the cost per day by position and the number of days to be worked by evaluation component, total salaries were derived for each component. The totals for salaries and related expenses are shown on the Component Budgets, Tables 2 and 3, at the end of this proposal.

Travel

These costs were calculated for two people to attend conferences as indicated in the narrative, including per diem, air fare, and ground transportation.

Mileage

Mileage figures were calculated using the 1981 SFHHS rate of 20 cents per mile, and the average monthly mileage rates of the professional staff. The evaluators will be going into dangerous neighborhoods in the evenings to interview families, and car transportation is a must. They simply cannot take public transportation.

Printing

Printing costs were calculated by projecting the number of forms that would have to be printed in duplicate on NCR paper at a rate of 17 cents per page.

Copying

Copying costs were calculated by projecting 30-page reports as indicated in the component descriptions; 100 page final reports for Components One and Two; and a 200 page final report for Component Three. All will be reproduced with 100 copies at a rate of $5.00 per 100 pages. Covers for the final reports were figured at rate of $2.00 each.

Data Processing

Data Processing costs include three major items. The first is a pro-rata share of the monthly rental fee for the Crememco micro-processor at $35 per day. Second, the cost of using the University of California, Berkeley computer on-line for higher-level analysis that Crememco cannot handle were budgeted at $7,000 per year, and distributed to the various components. Finally, the costs of purchasing ($3,500) a soft-ware package for human service programs that will be adapted (at a cost of $5,000) to the needs of in-home service programs was included in Component Three.

Client Incentives

Client incentives were calculated at a rate of $2 per person, with an average of four people in each family, three visits per family, for 290 families.

Typewriter

Typewriter rental was calculated at a base rate of $75 per month for 12 months per year, a total of $900 annually.

Telephone

Telephone costs were projected at a rate of $28.00 per month for each of two lines needed for each component.

Space

Space costs were calculated at a rate of 80 cents per square foot for two 19x22 foot offices. This rate

includes insurance, utilities, janitorial service, etc. One office is budgeted for each component at a rate of $344.40 per month.

Administrative Overhead

Administrative overhead was calculated at a rate of 25 percent of the total staff costs. This rate is below that of the Agency as whole.

Contigency

A 5 percent contingency fee was added to cover unanticipated expenses.

TABLE 2: Budget for Component Two-Decision Analysis

EXPENSES	Cost Per Year 1981	1982	1983
Staff			
Senior Evaluator Linda L. Remy, DSW	7,200	8,640	8,640
Data Analyst Stuart P. Hanson, DSW (Cand.)	6,345	5,250	8,850
Program Director Lou Fox, MSW, MPH	4,312	2,127	1,702
Secretary Linda Garcia	810	836	1,650
Data Entry Clerk	1,200	1,904	-0-
STAFF COSTS	19,867	18,757	20,842
Travel/Conferences	-0-	-0-	2,150
Mileage	240	150	75
Data Processing	3,780	3,605	3,955
Typewriter	900	900	450
Telephone	672	672	336
Printing Forms	1,035	-0-	-0-
Copies of Reports	150	1,030	1,030
Space	4,013	4,013	2,006
Administrative (25% Staff Costs)	4,967	4,689	5,210
SUB-TOTAL	35,624	33,816	36,054
Contingency (5% of Sub-Total)	1,181	691	1,802
TOTAL	37,405	35,507	37,856
GRAND TOTAL			110,768

TABLE 3: Budget for Component Three - Comprehensive Evaluation

	Cost Per Year 1981	1982	1983
Senior Evaluator Linda L. Remy, DSW	6,000	6,000	6,000
Data Analyst Stuart P. Hanson, DSW (Cand.)	4,050	9,300	6,600
Program Director Lou Fox	1,687	2,127	5,238
Intensive Evaluation Supervisor	8,713	11,628	9,595
Evaluation Worker 1	10,327	19,781	-0-
Evaluation Worker 2	6,771	10,043	-0-
Relief Evaluation Worker	1,026	3,424	-0-
Secretary	1,620	1,929	1,731
Data Entry Clerk	1,450	2,023	-0-
STAFF COSTS	41,644	66,255	29,164
Travel and Conferences	-0-	2,050	2,150
Mileage	1,000	1,700	-0-
Data Processing			
Computer Rental	700	1,435	770
On-Line Time	2,800	2,800	2,800
Software Purchase	-0-	3,500	-0-
Programmer	-0-	2,000	3,000
DATA PROCESSING COSTS	3,500	9,735	6,570
Client Incentives	3,480	3,480	-0-
Typewriter Rental	549	540	229
Telephone	672	672	336
Printing Forms	2,015	1,720	-0-
Copies of Reports	250	1,030	1,030
Space	4,013	4,013	2,006
Administrative (25% staff)	10,411	16,564	7,291
SUB-TOTAL	67,534	107,759	48,776

Contingency (5% Sub-Total)	3,377	5,387	2,438
TOTAL	70,911	113,146	51,214
GRAND TOTAL			235,271

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Campbell, D.T. and Stanley, J.C. Experimental and Quasi-Experimental Designs for Research. Chicago: Rand McNally, 1963.

Emlen, A., Lahti, J., Downs, G., McKay, A. & Downs, S. Overcoming Barriers to Planning for Children in Foster Care. USDHEW, ACYF, Children's Bureau, National Center for Child Advocacy. DHEW Pulication No. (OHDS) 78-30138.

Fanshel, D. Computerized Information for Child Welfare: The Availability and Capacities of Parents of Children in Foster Care for Service Involvement. New York: Columbia University School of Social Work, November, 1978.

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Fanshel, D. & Shinn, E.E. Children in Foster Care: A Longitudinal Investigation. New York: Columbia University Press, 1978.

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Jenkins, S. Norman, E. Filial Deprivation and Foster Care. New York: Columbia University Press, 1972.

Jones, M.A., Neuman, R., and Shyne, A.W. A Second Chance for Families: Evaluation of a Program to Reduce Foster Care. New York: Research Center, Child Welfare League of America, 1976.

Moos, R.H. Evaluating Correctional and Community Settings. New York: John Wiley and Sons, 1975.

Polansky, N.A., Chalmers, M.A., Buttenwieser, E. & Williams, D. "Assessing Adequacy of Child Caring: An Urban Scale." Child Welfare, July/August, 1978.

Stein, T.J., Gambrill, E.D. & Wiltse, K.W. Children in Foster Homes: Achieving Continuity of Care. New York: Praeger, 1978.

Swire, M.R. and Kavaler, F. Health Supervision of Children in Foster Care. Child Welfare, 57(9), November, 1978, pp. 563-569.

RESUMES OF PRINCIPAL STAFF

LINDA L. REMY

ADDRESS:

51 Loring Avenue, Mill Valley, CA 94941; (415) 381-0343

EDUCATION:

1980 DSW, School of Social Welfare, University of California, Berkeley
Examination Areas: Child Welfare, Social Learning Theory, Research Methods

1977 MSW, School of Social Welfare, University of California, Berkeley
Concentration: Organization, Planning, and Administration with emphasis on program evaluation, services to children and families, child and family law

1975 BA, New College of California, San Francisco, California
Major: Humanities Minor: Psychology

SUMMARY OF PROFESSIONAL WORK EXPERIENCE:

1981 - Project Director, Evaluation, Breakthrough. A three year evaluation of a women's alcohol prevention project located in Ventura, California. Funded by NIAAA to the California Women's Commission on Alcoholism. (40% FTE)

1980 - Research Director, Emergency Family Care Program, San Francisco Home Health Service, San Francisco, California. A three-year project to develop a decision-focused case management information system for a service to prevent children from entering foster care. (50% FTE)

1979 - Research and Evaluation Consultant, The Casey Family Program, El Cerrito, California. A five-year project to develop a micro-computer information system for a long-term foster care program with divisions in several western states. (10% FTE)

1979 - Senior Research Methodologist, The URSA Institute, San Francisco, California.
1980 Developed and implemented case management and program management information systems for a major national evaluation of domestic violence programs funded through LEAA.

1977 - Research Assistant, School of Social Welfare, University of California, Berkeley.
1978

1976 - Western Representative, Project on Law and Behavior, Houston, Texas
1977

1973 - Program Director, The Family Tree, a Division of Independent Learning Institute,
1975 Novato and San Rafael, California. A day program for autistic children.

1971 - Program Coordinator and Administrator, Behavior Therapy Institute, Sausalito,
1973 California. A training program for parents and foster parents with difficult or handicapped children.

Linda L. Remy

PUBLICATIONS:

Linda L. Remy and Jeffrey Fagan. (1979) Case Management Information System Operations Manual. San Francisco, California: The URSA Institute.

Linda L. Remy and Jeffrey Fagan. (1979) Program Management Information System Operations Manual. San Francisco, California: The URSA Institute.

These two manuals present a self-paced, individualized instruction format to train workers in domestic violence projects to complete forms developed for the national evaluation. The instruction units were tailored to the needs of specific workers in specific program components. The two manuals were accompanied by a Suggested Reading Syllabus and a variety of training aids to facilitate worker learning.

Jeffrey Fagan, Virginia Lewis, Linda Remy, Jeri Mersky and Douglas Stewart. (1979) National Evaluation Design for the LEAA Family Violence Program. San Francisco, California: The URSA Institute.

Lawrence H. Boyd and Linda L. Remy. (1979) "Foster Parents Who Stay Licensed and the Role of Training," Journal of Social Service Research, 2(4):373-388.

Lawrence H. Boyd and Linda L. Remy (1978) "Is Foster Parent Training Worthwhile?" Social Service Review, 52 (June): 275-296.

Contributing Author:

Jeffrey Fagan, Virginia Lewis, Gail Kaplan, Jeri Mersky, Elizabeth Friedman. (1979) First Interim Report: History and Development. The LEAA Family Violence Demonstration Program. San Francisco, California: The URSA Institute.

Contributing Author, Research Supervisor and Editor:

Arnold Katz. (1980) The One Parent Male Headed Family: Exploration of Changing Family Policy. Berkeley, California: University of California.

Meryl Esta Lipton. (1980) The Differential Dose Effects of Methylthenidate on Hyper Active Children and Their Mothers. Minneapolis, Minnesota: University of Minneapolis.

Editor:

L.H. Boyd, Jr. and Gudmund R. Iversen. (1979) Contextual Analysis: Concepts and Statistical Techniques. Belmont, California: Wadsworth Publishing.

List of unpublished papers available on request.

MARY LOU FOX

ADDRESS: 1201 Dolores Street, San Francisco, CA 94110; (415) 641-4526

EDUCATION:

1979 MPH, School of Public Health, University of California, Berkeley
Concentration: Maternal and Child Health

1974 MSW, The George Warren Brown School of Social Work, Washington University, St. Louis, Missouri
Concentration: Medical Social Work

1972 BA, St. Louis University, St. Louis, Missouri
Major: Sociology, Dean's List: 1968-1972

PROFESSIONAL WORK EXPERIENCE:

Nov 1980 - Present SAN FRANCISCO HOME HEALTH SERVICE, San Francisco, California
Director of Children Services - Total program responsibility for the pilot Emergency Family Care Program which includes recruitment of staff, initial and on-going training, directing program activities and developments, providing supervision and consultation to program and evaluation staffs, and continuing community coordinating efforts and fundraising activities.

July 1979 - Oct 1980 Coordinator of Children Services Conducted a county wide feasibility study to determine the need for in-home supportive services to families in crisis. Prepared a program proposal which provides for a range of emergency home-based services to preserve the family unit and improve family interaction while reducing out-of-home child placements. Subsequent fundraising efforts resulted in a one year budget that exceeds $300,000 and is supported by private funding sources and the San Francisco Department of Social Services.

June 1975 - Sept 1978 CARDINAL GLENNON MEMORIAL HOSPITAL FOR CHILDREN, St. Louis, Missouri
Medical Social Worker - Provided crisis intervention, short term, and long term social service intervention to children and their families on an in-patient and out-patient basis; managed over 100 cases of child abuse and neglect during a seven month demonstration project as the sole Child Abuse Worker in the largest out-patient pediatric hospital in the country; provided direct services and consultation as a multi-disciplinary team member working with the Child Abuse, Cystic Fibrosis, Plastic Surgery and Cleft Palate teams; provided on-going in-service training both within the hospital and with the Division of Family Services in relation to child abuse.

May 1973 - May 1978 PLANNED PARENTHOOD ASSOCIATION, St. Louis, Missouri
Medical Social Worker - Provided interviewing, family planning, counseling, teaching, consulting and referral work services.

SUPERVISORY EXPERIENCE:

Oct 1980 - Present San Francisco Home Health Service, San Francisco, California
Responsible for the direction and supervision of the Emergency Family Care Program and evaluation staffs.

Sept 1974 - May 1978 St. Louis University School of Medicine, Department of Community Medicine
Taught interviewing skills and the socio-economic factors of health care to first year medical students. Supervised medical students' community health projects.

May 1978 - August 1978 Cardinal Glennon Memorial Hospital for Children
Supervised a second year MSW student.

Mary Lou Fox

COMMUNITY INVOLVEMENT:

1976 - 1981 Conducted numerous training workshops and lectures on child abuse prevention, identification, and intervention for hospital personnel, graduate school classes, service providers and parent groups.

1979 - 1981 Provided professional and community education on the development and implementation of a 24 hour home-based family care service within a home health agency.

COMMUNITY COUNCILS/BOARDS:

1981 Member: San Francisco Child Abuse Council

1981 Member: Technical Advisory Committee, Division of Family and Children Services, San Francisco Department of Social Services

1980 Steering Committee Member and Chairperson: San Francisco Interagency Committee for High Risk Families

1978 Steering Committee Member: St. Louis Association of Medical Social Workers

1977 - 1978 Steering Committee Member: Metropolitan Council on Child Abuse and Nelgect

1977 Member: Task Force on the Interdisciplinary Treatment of Child Abuse and Neglect, sub-committee on Health, Governor's Committee on Children and Youth

1975 - 1978 Member: Cystic Fibrosis Gateway Chapter Council

1975 - 1974 Faculty Panel Member: St. Louis University School of Medicine, Department of Community Medicine

AWARDS:

1978 Maternal and Child Health Traineeship to attend the School of Public Health at Berkeley, California

RESUME

Stuart P. Hanson
456A Vassar Avenue
Berkeley, California 94708
Telephone: (415) 524-7315

PERSONAL DATA

Date of Birth:	August 15, 1946
Place of Birth:	Boston, Mass.
Marital Status:	Single

EDUCATION

1977-present

Doctoral Student, School of Social Welfare, University of California, Berkeley. Major teaching interests: epidemiology of mental disorders; organizational behavior; residential care; and research methods. Candidacy expected February 1981. Dissertation title(tentative): Work Groups and Decision Support Systems: A Sociological Study of California's In Home Supportive Services Program.

National Institute of Mental Health Traineeship 1977-78. 1978-79

1975-77

MSW, School of Social Welfare, State University of New York, Stony Brook. Major interests: social planning and social research. Thesis: Boarding Houses and State Mental Hospital Readmissions.

National Institute of Mental Health Traineeship 1976-77

1964-68

BA, Hamilton College, Clinton, New York. Major in history, minor in government. Thesis: The Right to Counsel from Colonial Times to 1920.

Dean Alfange Prize Essay in American Constitutional History

EMPLOYMENT

1980-present

Research Consultant: Bay Area Urban League Permanency Planning Project. Data analysis and report writing for a study of black children in the Alameda County foster care system.

Research Consultant: Center for the Family in Transition, Corte Madera. Data analysis for a study of the problems of divorce.

Teaching Assistant: School of Social Welfare, University of California, Berkeley. Masters level course in research methods. Lectures, Data analysis labs, and consultation with students on individual research projects.

1979-80

Teaching Assistant: School of Social Welfare, UCB. Doctoral level course in advanced research techniques. Computer labs using SPSS and other statistical programs; review sessions on course content; consultation with individual students. Full academic year.

Teaching Assistant: School of Social Welfare, UCB. Masters level course in research methods. See 1980-present. Full academic year.

1978-79

Teaching Assistant: School of Social Welfare, UCB. Doctoral level course in advanced research techniques. see 1979-80. Other duties included labs in computer programming ("Basic"). Full academic year.

1978

Mental Health Aide: Adolescent Treatment Program, "I" Ward, Contra Costa Hospital, Martinez, Ca. Counseling and treatment planning. Part time.

1976-77

Legislative Aide: Subcommittees on After Care and Patient Abuse New York State Assembly Standing Committee on Mental Health. Administation of legislative hearing, analysis, report writing, and bill drafting.

1973-75

Area Drug Coordinator: Division of Drug Rehabilitation, Department of Mental Health, Boston, Ma. Administrative, planning, and program evaluation responsibilities for Lowell, Ma. catchment area federal and state funded drug rehabilitation programs. Extensive work with community agencies.

1972-73

Senior Worker for the Blind: Massachusetts Commission for the Blind, Boston, Ma. Eligibility determination and casework services.

1971-72

Mental Health Aide: Lowell Mental Health Center, Lowell. Ma. Counseling, community organizing, and research.

1969-71

Squad Leader: U.S. Army Corps of Engineers.

PUBLICATIONS

Boyd, Lawrence H., Jr., Marleen Clark, and Stuart P. Hanson, "A Laboratory Study of A Worker-Centered Information System," EVALUATION QUARTERLY, October, 1980.

Harenberg, Paul, Stuart P. Hanson, and others, WARDS OF THE STATE: A REPOPT OF THE CAUSES, NATURE, AND EXTENT OF PATIENT ABUSE IN NEW YORK STATE MENTAL HEALTH FACILITES, Subcommittee on Patient Abuse, New York State Assembly Standing Committee on Mental Health, June 1977.

References will be furnished upon request

INTERNAL REVENUE SERVICE RULING

Internal Revenue Service

Department of the Treasury

District
Director

450 Golden Gate Ave., Box 36001
San Francisco, Calif. 94102

Person to Contact: Desk Officer

Telephone Number: (415) 556-5353

Refer Reply to: EP/EO:1

Date: 5 DEC 1980

San Francisco Home Health Service
225 - 30th Street
San Francisco, CA 94131

Gentlemen:

Reference is made to your request for verification of non-private foundation classification status of your organization.

In a letter dated October 20, 1970 we classified you as an organization that is not a private foundation as defined in section 509(a) of the Internal Revenue Code. It has been further determined that you are an organization as defined in 509(a)(2) of the Internal Revenue Code.

Your classification is based on the assumption that your operations will be as stated in your notification. Any changes in your purposes, character, or method of operation must be reported to your District Director so he may consider the effect on your status.

Our records indicate that there has been no change in your organizations exempt status.

Grantors and contributors may rely on this determination until the Internal Revenue Service publishes notice to the contrary. However, a grantor or a contributor may not rely on this determination if he or she was in part responsible for, or was aware of, the act or failure to act that resulted in your loss of section 501(c)(3) status, or acquired knowledge that the Internal Revenue Service had given notice that you would be removed from classification as a section 509(a)(2) organization.

Because this letter could help resolve any questions about your private foundation status, please keep it in your permanent records.

If you have any questions, please contact the person whose name and telephone number are shown above.

Sincerely yours,

Michael Sassi

District Director

RECEIVED
DEC 8 - 1980
S.F. Home Health Service

51 56